**Thank you for considering Brighter Access for your future home.**

**Please complete the following information** (Type your responses at the yellow placeholders)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **General Information** | | | | |
| **Participant name** |  | | **Date of Referral** |  |
| **NDIS Participant No:** |  | | **D.O.B.** |  |
| **Participant Contact No:** |  | | | |
| **Current Address** |  | | | |
| **Cultural Requirements** |  | | | |
| **Religion** |  | | | |
| **Gender** | Male  Female  Other  I do not wish to disclose this information | | | |
| **Language** | English  Other (specify): | | | |
| **Communication method** | Verbal  Other (specify): | | | |
| **Who do you currently live with?** | |  | | |
| **Where would you like to live?** | |  | | |
| **When would you like to move?** | |  | | |
| **I can share with the Opposite Gender** | | No  Yes Specify: | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Health Map** | | | | | | | **Comments** |
| **Primary diagnosis** |  | | | | | |  |
| **Other diagnoses**  **(Disability and Health)** |  | | | | | |  |
| **High Intensity Personal Daily Activities** | Complex Bowel Care  No  Yes | | Enteral Feeding  No  Yes | Severe Dysphagia  No  Yes | | Urinary Catheter Support  No  Yes |  |
| Subcutaneous Injections  No  Yes | | Complex Wound Care  No  Yes | Ventilator Management (inc. CPAP)  No  Yes | | Tracheostomy Support  No  Yes*:* |  |
| **Sleeping routines** |  | | | | | |  |
| **Drug / alcohol / cigarette use history or present** | No  Yes | (specify) | | (specify) | (specify) | | **Supports currently in place:** |
|  | |  |  | |  |
| **Current health conditions** |  |  | |  |  | |  |
| **Historical health conditions** |  |  | |  |  | |  |

| **Circle of Support** | | | | | | | | | **Comments** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Coordinator of Supports contact information** | Name | | Phone Number | | Email | | | Postal Address |  |
|  | |  | |  | | |  |
| **Person Responsible Contact Information** | Name | | Phone Number | | Email | | | Postal Address |  |
|  | |  | |  | | |  |
| **Guardian Contact Information /**  **Function Details** | Name | | Phone Number | | Email | | | Postal Address |  |
|  | |  | |  | | |  |
| **Trustee and Guardian** | No  Yes | | Phone Number | | Email: | | | |  |
|  | |
| **Family involvement** | Relationship  Name  Phone  Email | | | Relationship  Name  Phone  Email | Relationship  Name  Phone  Email | | Relationship  Name  Phone  Email | |  |
| **Family Contact (Detail family visit information)** |  | | | | | | | |  |
| **Work or Day Program Information** | Provider: |  | | | Provider: |  | | |  |
| Location: |  | | | Location: |  | | |
| Days: |  | | | Days: |  | | |
| Times: |  | | | Times: |  | | |

| **Support Needs** | | | | | | | **Comments** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Behaviours of concern** | I can be physically aggressive towards others  No  Yes | | I engage in physical aggression towards myself (Self-Harm)  No  Yes | I can be physically aggressive towards property  No  Yes | | I can be verbally aggressive towards others  No  Yes |  |
| I may abscond or accidentally walk off  No  Yes | | I have sexualised behaviours  No  Yes | *Other*: | | *Other:* |  |
| **Restrictive Practices Identified** | *Specify:* | | *Specify:* | *Specify:* | | *Specify:* |  |
| **Are RPA’s currently in place?** | No  Yes | | No  Yes | No  Yes | | No  Yes |  |
| **Access / Mobility Requirements** | I’m at risk of slip/trip/falls  No  Yes | | I need support with manual handling at times  No  Yes | I use a manual wheelchair  No  Yes | | I use an electric wheelchair  No  Yes |  |
| I use a walking frame  No  Yes | | I can self-transfer to bed or vehicle  No  Yes | I need to use a hoist when transferring  No  Yes | | I require bathroom modifications  No  Yes |  |
| I can walk without staff assistance (Independent)  No  Yes | I require staff assistance with walking:  Supervision  Standby assist   Minimal assist  Maximal assist | | | I can climb some stairs i.e., 2-3  No  Yes  *Specify*: | |  |
| **Vehicle / Transport Requirements** | I can travel in a passenger car  No  Yes | | I require a larger vehicle like a multi-passenger vehicle  No  Yes | I need a fold-down step or other vehicle modifications  No  Yes | | I need a wheelchair accessible vehicle with a hoist  No  Yes | *Other:* |
|  | I require driver protection screen (like a taxi screen)  No  Yes | | I use a harness or seatbelt guard  No  Yes | I can use public transport  No  Yes | | I walk to the shops unassisted  No  Yes | *Other:* |
| **Daily Living Requirements** | I need staff support all the time  No  Yes | | I need support with my health conditions e.g., epilepsy/ diabetes/bolus feeds  No  Yes | I need support to take my regular medication  No  Yes | | I can sleep through the night  No  Yes | *Other:* |
|  | I wake during the night and need staff support  No  Yes | | I need a second living area as I tend to make a lot of sounds  No  Yes | I have a hearing impairment  No  Yes | | I have vision impairment  No  Yes | *Other:* |
| **Transition Requirements** |  | | | | | | |
| **Any other Information you would like us to know** |  | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Extra Details** | | | | |
| **NDIS Plan** | Plan dates:  Agency Managed  Plan Managed  If Plan Managed, please provide Plan Manager details below     * Organisation: * Contact: * Email: * Contact number:   High Intensity Funding  No  Yes  SDA Funding  No  Yes - Amount $ . | | | |
| **Supported Independent Living (SIL)** | SIL funding approved: | | SIL balance remaining: | |
| **Social and Community Participation** | Social and Community Participation ratio approved (e.g. 1:1, 1:3) | Social and Community Participation funding approved in plan | | Social and Community Participation balance remaining |
|  |  | |  |
| **Person responsible for billing/payment and contact details:** | Name:  Email:  Contact number: | | | |
| **Centrelink Income Statement attached** | Yes ☐ To be provided ☐ Not applicable ☐ | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Next Steps**  **I would like to be considered for a placement in an Enlarge Home that suits and meets my needs and goals for Supported Independent Living**  **I currently have SIL funding and want to transfer from my current provider to Brighter Access, or**  **I have capacity to explore SIL in my current plan**  **I would like Enlarge / Brighter Access to organise a SIL quote for me to reside and be supported in an Enlarge Home** | | | |
| **Name of person signing application** | **Date** | **Role** | **Signature** |
|  |  |  |  |
|  |  |  |  |

Please fill out above the details before sending to our email address:

[mycare@brighteraccess.com.au](mailto:mycare@brighteraccess.com.au)

A member of our team will be in touch as soon as possible. Thank you!